KYLE WILLIAMS LMSW ACSW
Solution Focused Individual and Family Therapy

Insurance Reimbursement Addendum to the Treatment Agreement:

As a practice ("Kyle Williams LMSW ACSW"), I am enrolled in some managed care and traditional insurance plans in an effort to accommodate the related insurance reimbursement needs and requests of some of my clients.

While I am pleased to be able to provide this service to you, it is extremely difficult for me as an individual practitioner to track of all of the individual requirements of the various insurance plans.

Each plan has different stipulations regarding how often services may be rendered and, even more importantly, where those services may be performed. Even within the same insurance company, the plan may differ depending upon what type of contract the insured's employer has negotiated.

Unfortunately, if you do not inform me of plan coverages and benefit information, you will not receive the necessary payment from your insurance company. In such cases, you are ultimately financially responsible for full payment to my practice for services rendered.

Providing quality therapeutic care for my clients is my primary concern. I am willing to provide that care within your insurance contract guidelines, provided you let me know exactly what those guidelines constitute. I ask that you contact your insurance provider and collect all necessary information for reimbursement. Attached to this document is a form to request all of the information needed for the claim. Please complete all questions! This will save us time and save you a second call to your insurance company!

Secondly, I will ask that you take responsibility for following up with insurance claims submitted and not paid in a timely manner. Again, my primary concern is providing quality therapy in my practice. I am not a collection agent or a billing specialist. I ask that we work together to make this process helpful to both of us.

With your cooperation and providing necessary information, you should have no surprises and you should be able to receive all of the benefits offered by your employer and / or insurance provider.

Please let me know if you have additional questions regarding this policy.

I accept the Insurance Policy addendum to the Treatment Agreement:

Signed _____ Date _____
Client or responsible party

Signed _____ Date _____
G. Kyle Williams ACSW LMSW

All Information Required for Insurance Submission

(Please do not skip any question on the next two pages! HCFA forms require all of this info!)

Client Information

First Name_____ Last Name_____

Street Address _____

City _____State _____ Zip_____

Primary Telephone _____ Client's date of birth _____

Claim Information

Circle - Employment Status – please circle employed – **YES / NO / full time / part time**

Primary Insurance _____

Full Mailing Address: _____

Circle - Type of Insurance – Group, HMO, Medicare, Individual

Circle - Your relationship to Insured (self , spouse , child , other)

Insured Information:

Insured's ID Number_____ Insurance Company_____

Group Number (usually lower left corner of your card) _____

Insured's Date of Birth _____

Insured's employer _____

Insurance Plan Name _____

Do you have an additional health insurance plan? Yes / No

Insured's Name (if different from client info above)

Last_____, First_____

Insured's Street Address _____(if different from yours)

City_____ State_____ ZIP _____

Insured's date of birth _____

Primary telephone _____

Signature _____Today's Date _____

Pre-Authorization:

You must call your insurance company to inquire regarding your insurance coverage for behavioral heath services. Plans have a wide degree of variation and you are responsible for understanding the limits and benefits your plan offers.

To submit therapy services for medical reimbursement, I must submit a psychiatric diagnosis related to the treatment I provide. If you have questions regarding this issue, please ask!

Plan Coverage – get this information from your insurance provider's customer service telephone number on your card:

Insurance Plan contact number _____

Name of the person you are speaking with _____

Today's date: _____

Confirm that you have "behavioral health benefits for CPT codes 90791 and 90837" YES / NO

Are services covered with me as your provider YES / NO

Annual Deductible $_____ Individual $_____ Family $_____

Deductible met? YES / NO

Coverage Year begins (date) _____ Copay for office visits $_____

Authorization Number (if required) _____ Number of visits _____

Authorization dates (from ____/_____/2015 to _____/_____/20___)

Do you have HSA or reimbursement from your employer for deductible? Please describe:

_____

Practice Information:

My degree and relevant identifying information which your insurance provider may ask for:

Gregory Kyle Williams LMSW ACSW (some plans list me under Gregory, some Kyle)
- **Tax ID** - 90-0198689
- **NPI** - 1972752889 (national provider identification number)
- **LMSW** – 6801084481 (my state clinical social worker license)
- **ACSW** – 884799719 (some plans require my national certification for reimbursement)

Office Information:
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